MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

[redacted] 05682

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs, 1 mo, 12 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 2 yrs, 1 mos, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 615 North Carey Street (If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3.(a) FULL NAME: BAKER - JOHN (JAMES)

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Madeline Baker, 605 N. Mount St., Balto., Md. (c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): April 20, 1906

8. AGE: Years	Months	Days	If less than one day
39	1	13	--- hrs. --- min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER — 12. Name: John Baker

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Lottie Curtain

MOTHER — 15. Birthplace: South Carolina

18. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 6-5-45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt

Address: [illegible]

19. June 15 1945 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1945 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 1943 to June 3 1945 and that I last saw him alive on June 3 1945

Immediate cause of death	DURATION
Malignant Hypertension	Apprx. 2 yrs.
Due to ---	
Due to ---	
Other conditions: Epilepsy - Chronic Alcoholism (Include pregnancy within 3 months of death)	Known to us since 4/21/43

Major findings of operations: ---

Date of op. ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed 6/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (466)

CERTIFICATE OF DEATH

100 47 05685

Reg. Dist. No. 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore Anne Arundel

City or town Brooklyn (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Brooklyn (If outside city or town limits, write RURAL and give nearest town)

Street No. 216 E. Hendrey Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr. Thomas Edward Barrett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Justina Barrett

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) February 17, 1884

8. AGE: Years	Months	Days	If less than one day
59			hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Grain weigher

11. Industry or business Penna Elevator

FATHER 12. Name Wm. Barrett

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth Ledley

MOTHER 15. Birthplace Maryland

16. Informant Justina Barrett

Address 216 E. Hendrey Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23/45 (month) (day) (year)

Cemetery or ~~crematory~~ Mt. Olivet

Location Frederick Road

19. Funeral director Thenowith & Donovan

Address 3615-17 Christmas Ave

19. June 22 19 45 (Date rec'd by registrar) Ida M. Whitson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 19 45 at 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 19 45, to 6-20 19 45 and that I last saw h-- alive on 6-17-45 19

	DURATION
Immediate cause of death Metastic Lemorrhage	1 Day
Due to Carcinoma of Stomach	6 mo?
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Stomach Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lawrence B. Lerra M. D. or other

Address 11 E. Chase St Date signed 6-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 304

CERTIFICATE OF DEATH

05683

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sparksville
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ---------- ✓

3.(a) FULL NAME: BAYLOR - SIMON

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Elizabeth Baylor, Sparks, Maryland

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 8, 1902

8. AGE: Years	Months	Days	If less than one day
43	3	4	--- hrs. --- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: ----------

FATHER
12. Name: Simon Baylor
13. Birthplace: Virginia

MOTHER
14. Maiden name: Louise Wright
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 15, 1945 (month) (day) (year)

Cemetery or crematory: Stephen's Chapel Cemetery

Location: Sparks, Maryland

18. Funeral director: Landon M. Brooks

Address: Sparks, Maryland

19. June 12 1945 (Date rec'd by registrar) E. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 1945, at 5:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1945, to June 12 1945 and that I last saw him alive on June 12 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 5/28/45
Due to: ----------	
Due to: ----------	
Other conditions: ----------	

(Include pregnancy within 3 months of death)

Major findings of operations: ----------

Date of op. ----------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of ----------

Where did injury occur? ---------- (City or town) ---------- (County) ---------- (State)

Injured at home, farm, industry, public place (where?) ----------

Means of injury ---------- Injured at work? ----------

23. SIGNATURE: Herbert L. Brookover M. D. or other

Address: Crownsville, Maryland Date signed 6/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05684

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Gambrills Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Gambrills Md (R.F.D.)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Defense Highway Nr. Crain Highway
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Margaret Beiszer.
3. (b) Social Security Number None

4. Sex Female
5. Color or race white
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Adam Beiszer
6.(c) If alive, give age 78 years
7. Birth date of deceased (mo., day, yr.) July 25, 1875

8. AGE: Years 69 Months 10 Days 23 If less than one day ... hrs. ... min.

9. Birthplace Austria Hungary
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business Own Home.

FATHER
12. Name Peter Moritz
13. Birthplace Austria Hungary

MOTHER
14. Maiden name Margaret Waldner
15. Birthplace Austria Hungary

16. Informant Mrs. Margaret Doepkens
Address Davidsonville, Md

17. Burial Date thereof June 22-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory White Marsh Ch. yard.
Location Prince George's Co. Md.
18. Funeral director Thomas W Singleton
Address Glen Burnie, Md

19. June 22 1945 [signature] Dep Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945 at 4.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17-45 19 to June 18-45 19
and that I last saw her alive on June 17-45 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to	
Due to Hypertension & Generalized Arteriosclerosis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M.D. or other
Address [illegible] Date signed June 20-1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05686

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 36 Lincoln Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: BLOUNT - CHARLES J.

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Ruby Blount, 36 Lincoln Ave., Catonsville, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years	Months	Days	If less than one day
50	unknown		---hrs. ---min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: Stationary Engineer
11. Industry or business: ---

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: June 13, 1945 (month) (day) (year)
Cemetery or crematory: Western Store Cemetery
Location: Catonsville, Maryland

18. Funeral director: Mrs. Frances T. Hemsley
Address: 578 W. Biddle St., Balto., Md.

19. June 11 1945 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1945 at 8:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945 to June 10 1945 and that I last saw him alive on June 10 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: ---	
Due to: ---	
Other conditions: Acute Hallucinatory Confusional State (Include pregnancy within 3 months of death)	Prior to admission 6/7/45

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

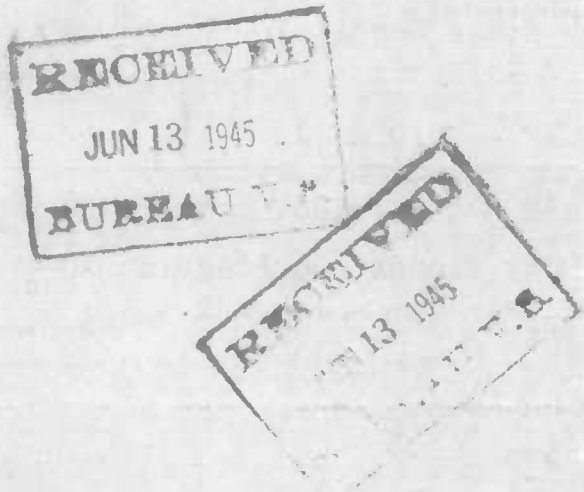
22. VIOLENCE: If death was due to external causes, fill in the following: ---
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Herbert V. Hunsicker M. D. or other
Address: Crownsville, Maryland Date signed: 6/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

CERTIFICATE OF DEATH

105687

Reg. Dist. No. 20

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Drury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? several years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Drury
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Cora M. Bowers.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Frank Bowers
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept. 17th 1873 1864

8. AGE: Years	Months	Days	If less than one day
71			hrs. min.

9. Birthplace: Bakersville Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Daniel Marmaduke
13. Birthplace: Md.

MOTHER
14. Maiden name: Alice Cooke
15. Birthplace: Md.

16. Informant: Mrs Rose B. Mercer
Address: 3419 - 24th st. NE. Wash. D.C.

17. (Burial, cremation, or removal. Which?) Date thereof: June 5th 1945 (month) (day) (year)
Cemetery or crematory: Bakersville Luth. Cemetery.
Location: Bakersville Md.
18. Funeral director: W. H. Chambers Co.
Address: Riverdale Md.

19. 6/3 45 (Date rec'd by registrar) W. H. Chester Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 June 1945, at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 April 1945, to 3 June 1945 and that I last saw h.. alive on 2 June 1945

Immediate cause of death	DURATION
Cardio-vascular renal disease.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hawkinsville Ga. Date signed: 3 June 45


RECEIVED
JUN 7 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

05688

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A.

City or town Freetown (If outside city or town limits, write RURAL and give nearest town) Mrs Ben Burns

How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County A. A.

City or town Freetown (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Laura Burley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	widow

6.(b) Name of husband or wife Joseph Burley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78			..... hrs. ..... min.

9. Birthplace a. a. Co. Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Samuel Gaithen

13. Birthplace md

MOTHER 14. Maiden name Josephine

15. Birthplace md

16. Informant Samuel Spencer

Address Freetown. md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28-45 (month) (day) (year)

Cemetery or crematory Mt. Calvary

Location a. a. Co. md

18. Funeral director James A Hayes

Address 142 W. Hill St

19. June 27 1945 (Date rec'd by registrar) M. McCarron Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 19.... at 9 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/10/45 19.... to 6/25/45 19.... and that I last saw h.. alive on 6/23/45 19....

Immediate cause of death	DURATION
Cerebral hemorrhage	1 day
Due to Chronic Cardiovascular Arteriosclerosis	indefinite
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Falconer M. D. or other

Address Glen Burnie Date signed 6/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05689

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A.
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 13 Locust Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ella Lee Burtis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Edward Burtis
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6th 1863

8. AGE: Years	Months	Days	If less than one day
81	11		hrs. min.

9. Birthplace Annapolis Md
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name John Thompson
13. Birthplace Annapolis Md

MOTHER
14. Maiden name Elizabeth Ebey
15. Birthplace Germany

16. Informant Nora Lee Burtis
Address Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 18 1945 (month) (day) (year)
Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis Md.
19. Funeral director John M. Taylor
Address Annapolis Md.

19. June 18 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945 at 11 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1942 to June 1945
and that I last saw h[illegible] alive on June 18 1945

Immediate cause of death	DURATION
Myocarditis & Mycardial Hemphysema	3 yrs
Due to	
Due to	
Other conditions Generalized Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C. Basil M. D. or other
Address Annapolis Md Date signed 6-17-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

CERTIFICATE OF DEATH

05690

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 26 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 4 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Upper Marlboro (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #25 (If rural, give LOCATION)
2.(a) If veteran, name war: ---------

3.(a) FULL NAME: BUTLER - DOMINIC

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

B.(b) Name of husband or wife: -------
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1864 ?

8. AGE: Years	Months	Days	If less than one day
81 ?	unknown		--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown
FATHER 12. Name: John Franklin Butler
13. Birthplace: Maryland
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. (Burial, cremation, or removal, which?) burial Date thereof: 6-15-45 (month) (day) (year)
Cemetery or crematory: Crownsville State Hospital
Location:
18. Funeral director: Dept.
Address:
19. June 15 1945 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1945 at 7:48A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 1945 to June 4 1945 and that I last saw him alive on June 4 1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis	Known to us since 1/8/45
Due to: ----------	
Due to: ----------	
Other conditions: Senile Psychosis - Simple Deterioration (Include pregnancy within 3 months of death)	Known to us since 1/8/45

Major findings of operations: ---------- Date of op.: ------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: -------
Where did injury occur? --------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --------
Means of injury: --------- Injured at work? -------

23. SIGNATURE: Fred V. Winebrodt M. D. or other
Address: Crownsville, Maryland Date signed: 6/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

05691

Reg. Dist. No. 25

1. PLACE OF DEATH:

County Anne Arundel

City or town Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months

Hospital, Institution, or street address where death occurred: 311 - Riverside Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 45 - N. Mechanic St. -

(If rural, give LOCATION)

2.(a) If veteran, name war -

3.(a) FULL NAME Hobart Cecil Carr.

3.(b) Social Security Number 705-10-6350

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Daisy S. Chevallier.

6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Sept. 14 1903

8. AGE: Years 41 | Months 9 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual occupation Engineer (Railroad)

11. Industry or business

FATHER 12. Name Oliver Carr

13. Birthplace West Virginia

MOTHER 14. Maiden name Luiza Carr

15. Birthplace West Virginia.

16. Informant Mrs. Daisy Carr (wife)

Address 311 - Riverside Rd. - Brooklyn

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 7 - 45 (month) (day) (year)

Cemetery or ~~crematory~~ Cumberland Md Cem

Location Cumberland Md

18. Funeral director Milton Schilling Co. Inc. 25 Md

Address 3914 S. Hanover St

19. June 5 1945 (Date rec'd by registrar) John M. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death Acute circulatory disease	Sudden.
Due to Alcoholism	3 years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gustave A. Bauder M.D. attending medical (M.D. or other)

Address Glen Burnie, Md. Date signed 6/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH (59)

05692

CERTIFICATE OF ~~STILL~~BIRTH (Birth and death)

Reg. Dist. No. 21

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

Fetal heart rate fell to 15 a minute before birth. There was a questionable heart beat and an occasional gasp for about half an hour after birth.

1. PLACE OF BIRTH:

County Anne Arundel

City or town Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:

Length of mother's stay in County
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland

County Asbury road, Riviera Beach

City or town P. O. Pasadena, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If RURAL give LOCATION)

3. Name of child RONALD LEE CARR

4. Date of birth June 17 1945 Hour 2.05 A.M.

5. Sex male

6. Twin or triplet 2nd twin

7. No. of weeks pregnancy 28

FATHER OF CHILD

8. Full name Randolph Ray Carr

9. Color W. 10. Age at time of this birth 33 yrs.

11. Usual occupation

MOTHER OF CHILD

12. Full maiden name Grace Catherine

13. Color W. 14. Age at time of this birth 35 yrs.

15. Usual occupation

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 4

(b) How many other children were born alive but are now dead? 1 (c) How many other children were *born* dead? -

17. Did child die before labor? yes During labor?

18. Pregnancy, complications of hypochromic anemia (good response to parenteral iron)

19. Labor: (a) Complications of premature rupture of membranes (b) Induced? no

20. (a) Was there an operation for delivery? yes (Yes or No)

(b) State all operations, if any breech extraction, completed in 45 seconds.

(c) Did child die before operation? yes

During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity, livid asphyxia, atelectasis.

(b) Maternal causes none

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature L. A. Blair, M.D.
(Specify if M. D., midwife, or other)

Address Pasadena, Md.

23. (a) Burial (Burial, cremation or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

24. (a) Funeral director Thos. Singleton

(b) Address Glen Burnie, Md.

25. (a) 6-17-45 (Date rec'd by registrar) (b) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

15693

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? Admitted Dead to Hospi

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virgina County:
City or town: Norfolk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2531 Ludlow St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I&II

3. (a) FULL NAME: CARTER, Joseph Fontaine
Service No.
3. (b) Social Security Number: 242-09-99

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

8.(b) Name of husband or wife: WIFE: Mable L. Carter
6.(c) If alive, give age: - - - years
7. Birth date of deceased (mo., day, yr.): 10-13-~~00~~ 1900

8. AGE: Years	Months	Days	If less than one day
44	8	0	....hrs. ....min.

9. Birthplace: New Jersey
(Town, county, and state)
10. Usual occupation: Navy
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Annapolis. Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: June 14/45 (month) (day) (year)
Cemetery or crematory:
Location: Norfolk Va

18. Funeral director: Ben L. Hopping
Address: 170 West, Annapolis, Md.

19. June 14 19 45 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Unknown 19 45, at ....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Postmortum exam 19 6-13-45 to ....19....
and that I last saw h.... alive on ....19....

Immediate cause of death	DURATION
Drowning	
Due to: Accidental	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.....
Autopsy results: Accidental Drowning
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide - - - - - Date of - - -
Where did injury occur? - - - - - - (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) - - - - - -
Means of injury - - - - - - - Injured at work?

23. SIGNATURE: Henry N. Sadler, Jr.
H.H. SADLER Lieut. USNR
M. D. or other
Address.... Date signed....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05694 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr, 2 mos, 5 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 1 yr, 2 mos, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1315 Upton Street
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: COMBS - ISAIAH

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	separated

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1912 (?)

8. AGE: Years: 33 ? Months: unknown Days: If less than one day: ---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER 12. Name: John Combs
13. Birthplace: Virginia

MOTHER 14. Maiden name: Sarah Mason
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-12-45 (month) (day) (year)
Cemetery or crematory: Mt. Auburn.
Location: Bulto

18. Funeral director: A. Halstead
Address: 918 Druid Hill Ave. Balto

19. 6/9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9 1945, at 2:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1944, to June 9 1945 and that I last saw him alive on June 9 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 4/4/44
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op. ---
Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of ---
Where did injury occur? --- (City or town) (County) (State) ---
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Herbert Hinderer M. D. or other
Address: Crownsville, Maryland Date signed 6/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05695

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County a a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 24 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a.

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 54 west St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Regina G. Cohen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	w	divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 2 - 1900

8. AGE:

Years	Months	Days	If less than one day
45		26	..... hrs. ..... min.

9. Birthplace New York (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Jacob Greenberg

13. Birthplace Russia

MOTHER

14. Maiden name Katherine Weitzman

15. Birthplace Russia.

16. Informant F. E. Weitzman

Address 18 west St annapolis. md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 29/45 (month) (day) (year)

Cemetery or crematory Hebrew Friendship

Location Baltimore. md

18. Funeral director B L Hopkins

Address annapolis md

19 June 29 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 45, at 2.30 (M)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 45, to June 28 19 45

and that I last saw h.. alive on 11 A.M. June 19 45

Immediate cause of death Carcinoma of Liver

DURATION

Due to Malignancy

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. E. Weitzman M.D.

Address 18 West St annapolis Md Date signed June 28-45

M. D. or other

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

05696

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs. 3 mos.

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 11 yrs. 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Federalsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown

(If rural, give LOCATION)

2.(a) If veteran, name war: ----------

3. (a) FULL NAME: Luther Martin Collins

3. (b) Social Security Number: ---------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: ---------

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1916

8. AGE: Years	Months	Days	If less than one day
29	unknown		..... hrs. ..... min.

9. Birthplace: Dorchester County (Town, county, and state)

10. Usual occupation: None

11. Industry or business: -----

FATHER — 12. Name: unknown

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: Rosalie Collins

MOTHER — 15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 6/23-45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Keefer

Address: Crownsville Md

19. 6/23 45 (Date rec'd by registrar) E-7 Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1945, at 12:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1934 to June 10 1945

and that I last saw him alive on June 10 1945

	DURATION
Immediate cause of death: Pneumonia	
Bronchial - (Terminal)	2 days
Due to:	
Due to:	
Other conditions: Albinotic Idiot	Prior to admission 3/7/34

(Include pregnancy within 3 months of death)

Major findings of operations: ----------

Date of op. ------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --------- Date of -------

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---------

Means of injury ---------- Injured at work? ------

23. SIGNATURE: Hal V. Hinds M. D. or other

Address: Crownsville, Maryland Date signed: 6/10/45

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

05697

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County A. Annapolis
City or town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cathedral St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles F. Cook.
3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Katherine Cook
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 1886
8. AGE: Years 59 | Months | Days | If less than one day ... hrs. ... min.
9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual occupation Teacher
11. Industry or business U.S. Naval Academy
FATHER
12. Name Andrew J. Cook
13. Birthplace Brooklyn N.Y.
MOTHER
14. Maiden name Susan Tippett
15. Birthplace Washington D.C.
16. Informant Harry C. Allen
Address Washington D.C.
17. Burial Date thereof June 18th 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington Va
18. Funeral director Lee Funeral Home
Address Washington, D.C.
19 June 16 1945 Wm. Brinch
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 4 45 P.M.
21. I CERTIFY that death occurred on the date above stated; Postmortem Examination June 16 1945

Immediate cause of death	DURATION
Coronary Embolism	sudden
Due to Coronary sclerosis	unknown
Due to	

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE John M. Claffy M.D. Deputy Medical Examiner M.D.
Address Annapolis, Md. Date signed 6/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

05698

Reg. Diat. No. 2-3

1. PLACE OF DEATH:
County Anne Arundel
City or town Glen Burnie, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 607 Maple Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William Henry Crispens

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife Elizabeth M. Nee Stein
6.(c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) November 10, 1861

8. AGE: Years	Months	Days	If less than one day
82	7	10	...hrs. ...min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name William Henry Crispens
13. Birthplace Germany

MOTHER
14. Maiden name Betty Sheeler
15. Birthplace Germany

16. Informant Mrs. Grace M. Hornberger
Address 421 E. Gettings St. Balto. 30 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23 1945 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Glen Burnie Md.
18. Funeral director Thomas W. Singleton
Address Glen Burnie, Md

19. June 22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1945, at 4.10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5th 1945, to June 20th 1945, and that I last saw him alive on June 19th 1945.

	DURATION
Immediate cause of death	
Due to Coronary Thrombosis	Few hours
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John Steenander M. D. or other
Address Glen Burnie Md Date signed 6/20/1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

05699

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: aa

City or town: Friendship

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: aa

City or town: Friendship

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Amos Crosby

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Mrs Bertha Crosby

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Dec 8, 1874

8. AGE: Years	Months	Days	If less than one day
70	6	10	...hrs. ...min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Walter Crosby

13. Birthplace: Md

MOTHER — 14. Maiden name: Susan Linder

15. Birthplace: Md

16. Informant: Mrs Virginia Crosby

Address: Friendship

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/20/45 (month) (day) (year)

Cemetery or crematory: Friendship.

Location: " Md

18. Funeral director: Harry Hutchins

Address: Owings. Md

19. 6/19 45 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 18 1945 at 7 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...1935... to ...June 18... 1945

and that I last saw h... alive on June 17 1945

Immediate cause of death	DURATION
arteriosclerosis	5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hyde W Ward M. D. or other

Address: Owings Md Date signed: 6/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

CERTIFICATE OF DEATH

05700 ★ Reg. Dist. No. 22

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Laurel (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred: District Training School

How long in hospital or institution? 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 2133 Newport Place N. W. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Wendell Dickerson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5-16-43

8. AGE: Years: 2 | Months: 1 | Days: 1 | If less than one day: hrs. min.

9. Birthplace: Gallinger Hosp. Washington D.C. (Town, county, and state)

10. Usual occupation: inmate

11. Industry or business

FATHER 12. Name: Joseph Dickerson

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Rachel Thurston, (Deceased)

MOTHER 15. Birthplace: Virginia

18. Informant: records of District Training School

Address: Laurel, Maryland

17. removal (Burial, cremation, or removal. Which?) Date thereof June 18-45 (month) (day) (year)

Cemetery or crematory: Lowisa Co

Location: V2

18. Funeral director: L. E MURRAY-Son

Address: 1337-10 St NW Wash D.C.

19. June 18 19 45 (Date rec'd by registrar) Lelaia Barbee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 19 45, at 10.50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 19 45, to June 17 19 45 and that I last saw him alive on June 16 19 45

Immediate cause of death	DURATION
epileptic convulsion	life
Due to: organic brain disease	life
Due to:	
Other conditions: congenital organic brain disease with idiocy, amaurosis, epilepsy, and malformation of feet (Include pregnancy within 3 months of death)	life

Major findings of operations: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clay M Drummond M.D. M. D. or other

Address: District Training School Date signed 6-17-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

05701

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Camp Parole
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel County

City or town: Camp Parole
(If ontside city or town limits, write RURAL and give nearest town)

Street No. ----------
(If rural, give LOCATION)

2.(a) If veteran, name war: ----------

3.(a) FULL NAME: Diggs - Thomas

3.(b) Social Security Number: ----------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widowed

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 1873

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
72	-----	--	---	

9. Birthplace: Maryaldn (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: John Thomas Diggs

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Sarah Boston

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-21-45 (month) (day) (year)

Cemetery or crematory: Fowlers

Location: Best Gate Md

18. Funeral director: Ethel F. Hicks.

Address: 45 N.W. Street Annapolis

19. June 20 1945 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18, 1945 at 5:00 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8, 1945 to June 18 1945 and that I last saw him alive on June 18 1945

Immediate cause of death: General Arteriosclerosis — DURATION: Prior to admission. 6/8/45

Due to:

Due to:

Other conditions: Psychosis with cerebral arteriosclerosis.
(Incinde pregnancy within 3 months of death)

Major findings of operations: ------ Date of op.

Autopsy results: ------

PHYSICIAN: Please nuderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of ---

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other

Address: CROWNSVILLE, MARYLAND Date signed 6/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

T5702

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: School St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Janie R. Dorry.

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: William D. Dorry
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): April 4th 1877
8. AGE: Years: 68 Months: 1 Days: 30 If less than one day: hrs. min.
9. Birthplace: A. A. Co. Md. (Town, county, and state)
10. Usual occupation: House
11. Industry or business
FATHER 12. Name: Hezekiah Ward
13. Birthplace: A A Co Md.
MOTHER 14. Maiden name: Sarah Elizabeth Rodgers.
15. Birthplace: A.A. Co Md.
16. Informant: Mrs Harvey Mason
Address: 418 Severn Ave Eastport
17. Buried (Burial, cremation, or removal. Which?) Date thereof: June 8-1945 (month) (day) (year)
Cemetery or crematory: St James
Location: Near Harwood A A Co Md.
18. Funeral director: John M. Taylor
Address: Annapolis Md.
19. June 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6th 1945 at 9 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945 to June 6 1945
and that I last saw her alive on June 6 1945

	DURATION
Immediate cause of death: Myocarditis ch. & Myocardial Insufficiency	3 months
Due to: Arteriosclerosis	about
Due to:	
Other conditions: Rheu. Deformans (arthritis)	about

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C Bond M. D. or other
Address: Annapolis Md Date signed: 6-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

05703

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A. Co
City or town GREENLAND - BEACH
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County A. A Co.
City or town GREENLAND BEACH.
(If outside city or town limits, write RURAL and give nearest town)
Street No. WELDON ROAD.
(If rural, give LOCATION)
2.(a) If veteran, name war -

3. (a) FULL NAME ANNA. K. ENGELBACH.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEM	WHITE	WIDOW

6.(b) Name of husband or wife GEO. M. ENGELBACH
6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) MAY. 1st 1862

8. AGE: Years	Months	Days	If less than one day
83	1	13	hrs. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual occupation NONE
11. Industry or business

FATHER
12. Name HENRY. SCHMIDT.
13. Birthplace GERMANY.

MOTHER
14. Maiden name LOUISA. WANEKE
15. Birthplace GERMANY.

16. Informant MRS LOUISA. M BAKER
Address GREENLAND BEACH CURTIS BAY P.O.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JUNE 18-1945 (month) (day) (year)
Cemetery or crematory LOUDON PARK
Location BALTO MD
18. Funeral director Bernard C Harle
Address 121 E West St

19. June 15 1945 (Date rec'd by registrar) A. M. Hedrick A.E.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945 at 9 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/10 1935 to 6-14 1945 and that I last saw her alive on 6/14 1945

Immediate cause of death	DURATION
Acute Cardiac Failure	1 da
Due to Cardiovascular Renal	10 yr
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph H. Laukaitis M.D. M. D. or other
Address 619 Washington Blvd Date signed 6/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 872

05704

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
County Anne Arundel
City or town Fair Haven
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County
City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6301 - 14th St NW
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME JOHN THOMAS EVERETT

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single (Only)

6.(b) Name of husband or wife
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 7 1940

8. AGE: Years 5 | Months 1 | Days 28 | If less than one day ... hrs. ... min.

9. Birthplace Washington DC (Town, county and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John E. Everett
13. Birthplace Washington DC

MOTHER 14. Maiden name Margaret D. Davis
15. Birthplace Penn -

18. Informant Mrs. John E. Everett
Address 6301 - 14th St NW Wash DC.

17. Burial (Burial, cremation, or removal, Which?) Date thereof June 13 - 45 (month) (day) (year)
Cemetery or crematory Ft Lincoln
Location Prince Georges Co Md
18. Funeral director The S.H. Hines Co
Address 2901 - 14th St NW

19. June 10 1945 (Date rec'd by registrar) J.B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10 19 45 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated: [redacted] from
Postmortem Examinations
[redacted] June 10 19 45

Immediate cause of death — DURATION

Complications — Frequently since birth
Due to generalized Cerebral hemorrhage at birth.
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work? Deputy

23. SIGNATURE John M. Caffey M.D., Medical Examiner
M. D. or Other
Address Annapolis, Md Date signed 6/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
JUN 12 1945

MARYLAND STATE DEPARTMENT OF HEALTH

05705

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Parole Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her life
Hospital, institution, or street address where death occurred:
Parole Md.
How long in hospital or institution? ********** ********** **********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Annae Arundel
City or town: Parole Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Parole Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Eliza Dennis Fletcher

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: ~~Wife~~ William Fletcher
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 1, 1867

8. AGE: Years	Months	Days	If less than one day
77 77		17	..... hrs. ..... min.

9. Birthplace: South River Md. A. A. Co. (Town, county, and state)
10. Usual occupation: Teacher
11. Industry or business: None

FATHER
12. Name: Rev. Alexander Dennis
13. Birthplace: West River Md.

MOTHER
14. Maiden name: Sedonia Thompson
15. Birthplace: West River Md.

16. Informant: Mr William Fletcher
Address: Parole Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/20/45 (month) (day) (year)
Cemetery or crematory: Brew Hill Cemetery
Location: West St. Extd.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. June 20 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17, 1945, at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 43 to June 17, 1945 and that I last saw h alive on June 17, 1945

Immediate cause of death	DURATION
Heart Failure	
Due to Chronic Myocarditis	1 year
Due to	
Other conditions Arterio Sclerotic Hypertension	14 months

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. F. Preston Dow M. D. or other
Address: Annapolis Md. Date signed 6/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05706

Reg. Dist. No. 21

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: East Port Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All his life

Hospital, institution, or street address where death occurred:
618 2d St. East Port Md.

How long in hospital or institution? ××× ××××××××

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: East Port Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 618 2d St. East Port Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Joseph Forester

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Hattie Forester

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 18, 1890

8. AGE: Years	Months	Days	If less than one day
54 54	6	7	..... hrs. ..... min.

9. Birthplace: West River A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER
12. Name: Thomas Forester
13. Birthplace: Calvert Co. Md.

MOTHER
14. Maiden name: Annie Tasker
15. Birthplace: Calvert Co. Md.

16. Informant: Mrs Hattie Forester

Address: 618 2d St. East Port Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/29/45 (month) (day) (year)

Cemetery or crematory: Brew Hill Cemetery

Location: West St. Extd.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. June 29 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 19 45, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 2 19 44, to June 26, 19 45

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Paralysis	1 yr.
Due to: Spinal Tumor, malignant, of cervical region. Op. ?	
Due to:	
Other conditions: degeneration of spinal tracts	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Theodore L. Johnson M.D. M. D. or other

Address: 35 Northwest St. Date signed 6/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

CERTIFICATE OF DEATH

05707 Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Glenburnie R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Rural - Glen Burnie R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Lombardee Beach Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Charles J. Francisco

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Amy Francisco

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Feb 16. 1880

8. AGE:

Years	Months	Days	If less than one day
65	4	7	...hrs. ...min.

9. Birthplace: Cooks Falls. N.Y.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: U.S. Coast Guard

FATHER
12. Name: Neal Francisco
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Amy Francisco
Address: Lombardee Beach Rd A.A.Co Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 25. 1945 (month) (day) (year)

Cemetery or crematory: Laurel Grove

Location: Port Jervis N.Y.

18. Funeral director: Mr. Mrs. John W. Tetfel & Son

Address: 801 W. Fayette St.

19. 6/25 19 45 (Date filed by registrar) D.B. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 1945 at 10-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1945, to June 23 1945

and that I last saw ...alive on June 23 1945

Immediate cause of death	DURATION
a Uremia	2 days
Due to: myocardial	
Due to: asthma	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of -

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work? no

23. SIGNATURE: Thos. H. Phillips M. D. or other

Address: 1939 Edmondson Ave. Date signed: 6-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 15708 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County: Anne Arundel
City or town: near Laurel - R.F.D. #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? did not live here
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: near Laurel (not in A.A. County)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Brock Creek Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME John Thomas Gaither

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15, 1917

8. AGE: Years: 28 | Months: 3 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Anne Arundel Co. near Laurel
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: John Thomas Gaither
13. Birthplace: Anne Arundel Co. Md

MOTHER
14. Maiden name: Emma Nichols
15. Birthplace: Mt. Airy, Carroll Co., Md

16. Informant: John Gaither
Address: Laurel R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 1 1945 (month) (day) (year)
Cemetery or crematory: Bacons Cemetery
Location: Bacons near Laurel A.A. Co.

18. Funeral director: Rich. Selby Selby
Address: 401 West Ave Laurel Md

19. July 1 1945 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1945, at 9 45 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination to ~~and that I last saw h alive on~~ June 29 1945

Immediate cause of death	DURATION
Gun Shot wound in Chest	sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 6/29/45
Where did injury occur? near Laurel (City or town) not in A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) in Parkers Wood
Means of injury: Shot gun Injured at work? No

23. SIGNATURE: John M. Caffy, M.D., Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 6/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

05709

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Hanover Md R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Hanover Md. R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ridge Road Box 17
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph L. Geyman Sr

3.(b) Social Security Number: 717-07-6845

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Emma R Geyman
Nee Sherwood 6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.): December 7, 1871

8. AGE:

Years	Months	Days	If less than one day
73	6	17	...hrs. ...min.

9. Birthplace: Hanover Md R.F.D. Ridge Rd.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Thomas S Geyman
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Josh ISNa LeMarchant
15. Birthplace: Howard Co. Maryland.

16. Informant: Mrs Joseph L. Geyman
Address: Hanover, Md. R.F.D. Box 17

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 23, 1945 (month) (dsy) (year)
Cemetery or crematory: Meadow Ridge
Location: Washington Blvd, Howard Co Md.

18. Funeral director: Thomas W Singleton
Address: Glen Burnie, Md.

19. June 22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19, 1945 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 1945, to June 19, 1945 and that I last saw h[illegible] alive on June 18 1945

Immediate cause of death: Coronary Thrombosis — DURATION: 2 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edgar A. Mulley, M.D.
Address: 2623 Washington Blvd M.D. or other
Date signed: 6/19/45

05710

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
5 Clay Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Clay Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Martha Pinnetta Green

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1924

8. AGE: Years	Months	Days	If less than one day
20	10	4	..... hrs. ..... min.

9. Birthplace Belmar, N.J.
(Town, county, and state)

10. Usual occupation Maid

11. Industry or business

FATHER
12. Name Thomas Green
13. Birthplace Skidmore, Md.

MOTHER
14. Maiden name Ethel Martin
15. Birthplace Skidmore, Md.

16. Informant Ethel Colbert
Address Skidmore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17 1945 (month) (day) (year)

Cemetery or crematory Broadneck

Location ~~Broadneck~~, St. Margretts, Md.

18. Funeral director J.B.Johnson

Address Annapolis, Md

19. June 17 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1945, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~first attended deceased from~~ Post mortem Examination 19 ..... Attended last sick person ~~alive~~ June 13 1945

Immediate cause of death	DURATION
Pending	
Due to Acute congestive heart failure. Cor. R.	
Due to From Autopsy report	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results 6/14/45 - Pending

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE John N. Caffey M.D. Deputy Medical Examiner
M. D. or other

Address Annapolis, Md. Date signed 6/15/45

Dr. Claffy

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

T 05711

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Camp Parole (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ruth Gross
3.(b) Social Security Number:

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): July 14, 1923.

8. AGE: Years	Months	Days	If less than one day
21	11	16	... hrs. ... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:

FATHER
12. Name: James Gross
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Rachiel Bias
15. Birthplace: A.A.Co.

16. Informant: Rachiel Gross
Address: Parole, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 10 1945 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis, M
18. Funeral director: J.B.Johnson
Address: Annapolis, Md.

19. June 8 1945 (Date rec'd by registrar)
Registrar: [signature] B.W.

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 1945, at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; Postmortem Examination ... 19.. June 6 1945

Immediate cause of death: Bullet Wound in Chest

DURATION

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results: Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of: 6/5/45 - 11:15 PM
Where did injury occur? Parole, Anne Arundel, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Harlem Grill Beer Garden
Means of injury: Shot Injured at work? No

23. SIGNATURE: John M. Claffy M.D. Deputy medical Examiner
Address: Annapolis, Md. Date signed: 6/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 05712

Reg. Diat. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Revell Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Revell Station
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Y. Hall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Lottie Hall
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 12 1866

8. AGE: Years: 78 | Months: 7 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: A A Co Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER 12. Name: Thomas Hall
13. Birthplace: A A Co Md.

MOTHER 14. Maiden name: Mahoney
15. Birthplace: Unknown

16. Informant: Mrs Bernard Frantom
Address: Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22 1945 (month) (day) (year)
Cemetery or crematory: Asbury
Location: Arnold Md.

18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. June 22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20, 1945 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945 to June 20 1945
and that I last saw h.. alive on June 20 1945

Immediate cause of death: Acute Dilatation of
Due to: the Heart — Duration: 2 hours
Due to:
Other conditions: Arteriosclerotic Cardio-Vascular Disease — Duration: 5 yrs
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert R. Anderson M.D.
M. D. or other
Address: Annapolis Md. Date signed: 6/20/45

VS A15 MARGIN RESERVED FOR BINDING PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MV

05713

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Orchard Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: North Carolina County:
City or town: Greensboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Leila Harris

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 2. 1897.

8. AGE: Years	Months	Days	If less than one day
47	11	9	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: House Keeper

11. Industry or business

FATHER
12. Name: James S. Harris
13. Birthplace: N. C.

MOTHER
14. Maiden name: Magaret Wolfrdet
15. Birthplace: N. C.

16. Informant: Josephine Harris
Address: 3462 Childs Court

17. Removal — Date thereof: June 12 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Rafzy N. C.
Location

18. Funeral director: Martin J. Conroy
Address: 1600 Hollins st.

19. June 12 1945 (Date rec'd by registrar) — M S DeAlba, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1945, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination 19 ~~and last saw h... alive~~ June 11 1945

Immediate cause of death	DURATION
Drowning	sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident — Date of: 6/11/45
Where did injury occur? near Orchard Beach A.A. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Stony Creek
Means of injury: Auto plunged into Creek — Injured at work? No

23. SIGNATURE: John M. Claffy M.D., Deputy Medical Examiner
Address: Annapolis, Md. — Date signed: 6/11/45

Evidence for change of age is shown on

FILM No G 95 JUN 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (84)

CERTIFICATE OF DEATH

T 05714 sc

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 205 Amity Street

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME

HENSON - DOROTHY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Clarence Henson

6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1923

8. AGE: Years	Months	Days	If less than one day
22 ~~32~~	unkn	own	---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER

12. Name: John Brooks

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary Reverts

15. Birthplace: Maryland

16. Informant: Hospital records

Address: Crownsville State Hospital

17. (Burial, cremation, or removal. Which?) Date thereof June 4-1945 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Baltimore City

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantley ave

19. 6/11 (Date rec'd by registrar) 1945 E. Hoyle Reed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1945 at 11 30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1945 to June 1 1945 and that I last saw h.. alive on June 1 1945

Immediate cause of death	DURATION
Exhaustion	
Due to: Schizophrenia	
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herbert V. Brookes M. D. or other

Address: Date signed:

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

05715

Reg. Diat. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Anne Arundel

City or town: Herald Harbor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Herald Harbor, Crownsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Kyle Road.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Edward Hilleary

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widower

6.(b) Name of husband or wife: Rosalie Hilleary

Nee Painter

6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): Oct. 12. 1886

8. AGE: Years: 58 | Months: 7 | Days: 28 | If less than one day: ... hrs. ... min.

9. Birthplace: Mount Airy (Town, county, and state) Maryland

10. Usual occupation: machinist

11. Industry or business: Mark. D.P. Navy Yard.

FATHER 12. Name: Chas. A. Hilleary

FATHER 13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Josephine Moxley

MOTHER 15. Birthplace: Baltimore Md.

16. Informant: Mrs. Virginia P. Harrison

Address: Herald Harbor, Crownsville, P.O., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13, 1945 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln

Location: Bladensburg, P.G.Co. Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. June 11 1945 (Date rec'd by registrar) M. DeAlva Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1945, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated: [redacted] Post Mortem Examination

[redacted] June 10 1945

Immediate cause of death	DURATION
Cardiac Asthma	1 hour
Due to: Chronic Myocarditis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: John M. Cleffy M.D. Deputy Medical Examiner

Address: Annapolis Md Date signed 6/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

05716 21

Reg. Diat. No. .....

1. PLACE OF DEATH:

County: a. a. Co.

City or town: Riva

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: .....

City or town: Balto.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 410 Patapsco Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Lula Mae Holmes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Frank Holmes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 9th 1873

8. AGE: Years	Months	Days	If less than one day
71	11	3	.....hrs. .....min.

9. Birthplace: Penna.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER — 12. Name: (unknown) Stauffer

FATHER — 13. Birthplace: "

MOTHER — 14. Maiden name: "

MOTHER — 15. Birthplace: "

16. Informant: Francis W. Holmes

Address: 417 E. Biddle St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/15/45 (month) (day) (year)

Cemetery or crematory: London Park

Location: Balto. Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. 6/13 19 45 (Date rec'd by registrar) Wm. Hebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 12 19 45 at 3.30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11 19 45 to June 12 19 45 and that I last saw h.e alive on June 12 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	18 hrs.
Due to	
Due to	
Other conditions: Chr. endocarditis	?

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. J. Klemans, Md
M. D. or other

Address: 31 Smithgate Av Date signed: 6/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

CERTIFICATE OF DEATH

05717

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred:
Combat Range, Ft. George G. Meade, Md.
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Hawaii County: -
City or town: Kohala
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Box 50
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: INKYO, Sueichi -

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	JP	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: -years

7. Birth date of deceased (mo., day, yr.): November 29, 1923

8. AGE:	Years	Months	Days	If less than one day
	21	6	-	...hrs. ...min.

9. Birthplace: Kohala, Hawaii (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army
FATHER 12. Name: Unknown
13. Birthplace:
MOTHER 14. Maiden name: Naka Inkyo
15. Birthplace: Unknown
16. Informant: Service Record
Address: U. S. Army
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/2/45 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Washington D. C.
18. Funeral director: Howard H. Blight Jr.
Address: 4914 Belair Road
19. 30 June 19 45 (Date rec'd by registrar) W. J. Lawson (Registrar)
W.J. LAWSON, Jr 1st Lt MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 June 19 45, at 10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on 29 June 19 45, to ~~—~~ 19—
and that I ~~last~~ saw him alive on ~~—~~ 19
Immediate cause of death: Penetrating wound, left side, head
Due to: Grenade explosion
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION: Sudden

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 29 June 45
Where did injury occur? Ft Meade (City or town) Anne Arundel (County) Maryland (State)
Injured at home, farm, industry, public place (where?): Military Reservation
Means of injury: Grenade Injured at work? Yes

23. SIGNATURE: James H. Matthews Capt. MC
JAMES H. MATHEWS, Capt. M. D. or other
Address: Regional Hosp, Ft Meade, Md. Date signed: 30 Jun 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

05725

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Boy Irby.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24th 1945

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Annapolis Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Robert E. Irby

13. Birthplace South Boston Va.

MOTHER 14. Maiden name Myriam Owen

15. Birthplace Greth Boston Va.

16. Informant Robert E. Irby

Address Fair Haven Anne Arundel Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26th 1945 (month) (day) (year)

Cemetery or crematory

Location Lorette Boston Va

18. Funeral director John M. Taylor

Address Annapolis Md.

19. June 25, 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 1945, to June 25 1945; and that I last saw him alive on June 24 1945

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emily H. Wilson M. D. or other

Address Lothian Md. Date signed 6/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

T 05718

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 94 Clay Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rebecca Jackson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Charles Jackson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 6, 1865

8. AGE: Years	Months	Days	If less than one day
79	8		hrs. min.

9. Birthplace: Annapolis, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Charles Jackson
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 10, 1945 (month) (day), (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis, Md.

18. Funeral director: J. B. Johnson
Address: Annapolis, Md.

19. June 9 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7 1945 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14, 1945, to June 7, 1945
and that I last saw h alive on 1945

Immediate cause of death	DURATION
Cerebro Myocardial Failure	5 days.
Due to: Lobar Pneumonia	5 days.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B. H. Richardson M. D. or other
Address: Annapolis, Md. Date signed: 6/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (466)

CERTIFICATE OF DEATH

45719

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: a. a County

City or town: Brooklyn Heights md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a. a. County

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. 401 E. Townsend Ave (25)

(If rural, give LOCATION) Brooklyn Heights

2.(a) If veteran, name war:

3.(a) FULL NAME Sidney T. James

3.(b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna S. James

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 7th 1902

8. AGE:

Years	Months	Days	If less than one day
42	7	1	..... hrs. ..... min.

9. Birthplace: London England (Town, county, and state)

10. Usual occupation: Proprietor Restaurant

11. Industry or business: "

FATHER

12. Name: Benj. James

13. Birthplace: England

MOTHER

14. Maiden name: Eva Groves

15. Birthplace: England

16. Informant: Mrs Annd James

Address: 401 E. Townsend Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 11-45 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Gov. Ritchie Highway

18. Funeral director: Milton Schilling

Address: 3914 S. Hanover St

19. June 9 19 45 Ida M. Williams

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8th 19 45 at 1215 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 45 to June 8 19 45

and that I last saw him alive on 6/7/45 19.....

Immediate cause of death	DURATION
Due to Cancer of the Stomach	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Samuel Rubin M.D.

M. D. or other

Address: 203 Baltapsco ave Date signed: 6/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05724

93-d

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 30 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. ------ (If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME: Johns - Rosie

3.(b) Social Security Number: -----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Married

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: ------ years

7. Birth date of deceased (mo., day, yr.): ----

8. AGE: Years	Months	Days	If less than one day
82	---		hrs. ---- min.

9. Birthplace: Maryland (town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER 12. Name: ------

13. Birthplace: ---

MOTHER 14. Maiden name: -----

15. Birthplace: ---

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 7-5-45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt. of Hospital

Address:

19. July 5 1945 (Date rec'd by registrar) E. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1945, at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to June 21 1945 and that I last saw her alive on June 21 1945

Immediate cause of death	DURATION
Chronic Myocarditis	2yrs.
Due to	
Due to	
Other conditions: Dementia Praecox-Paranoid Type (Include pregnancy within 3 months of death)	

Major findings of operations: ----

Date of op.: ---

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: --- Injured at work?

23. SIGNATURE: Albert L. Meiskeads M. D. or other

Address: Crownsville, Maryland Date signed: 6/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

★ 05723

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel Md.
City or town: Davis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James W. Johnson

3.(b) Social Security Number: 579-10-6494

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C.	M.

6.(b) Name of husband or wife: Florence E. Johnson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 16, 1889

8. AGE: Years	Months	Days	If less than one day
56?			hrs. min.

9. Birthplace: Calvert Co. Md. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER — 12. Name: Clifton Johnson.
13. Birthplace: Md.
MOTHER — 14. Maiden name: Eliz. Owens
15. Birthplace: Md.
16. Informant: Thomas Dealt
Address: 3412 H. St, N.E. Wash, D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 18 1945 (month) (day) (year)
Cemetery or crematory: Mt Carmel
Location: Upper Marlboro Md
18. Funeral director: Robert T. McGuire
Address: 1820 - 9th St. N.W. Wash D.C.
19. (Date rec'd by registrar) June 18th 1945 — (Registrar) H. P. Clayton

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1945, at 7 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1945, to June 16 1945 and that I last saw him alive on June 16, 1945.

Immediate cause of death	DURATION
Apoplexy	3 days
Due to: Hypertension	?
Due to: Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: F B Heat M.D. (M. D. or other)
Address: Pasadena Md. Date signed: 6/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27

CERTIFICATE OF DEATH

05720

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, Institution, or street address where death occurred:
104 Calvert St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 104 Calvert
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Edgar Kenneth Jones

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 27, 1944

8. AGE: Years	Months	Days	If less than one day
X	5	11	____ hrs. ____ min.

9. Birthplace: Annapolis A.A. Co. Md (Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: Kenneth Jones
13. Birthplace: Waterbury Md.

MOTHER
14. Maiden name: Mary Brown
15. Birthplace: Annapolis Md.

16. Informant: Mary Brown
Address: 104 Calvert St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/9/45 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West St. Md.

18. Funeral director: Ethel L. Hicks
Address: 45 Northwest St. Annapolis Md.

19. June 9 19 45 (Date rec'd by registrar)
Registrar: C. O. Jones

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8 19 45, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 19 45, to June 8 19 45
and that I last saw him alive on June 8, 1945 19
Immediate cause of death: Dysentery — DURATION: 4 days
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I. B. Johnson M.D. M. D. or other
Address: 35 Northwest St Annapolis Md. Date signed: 6/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 39

CERTIFICATE OF DEATH

Reg. Dist. No. 5721 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
Emergency Hospt.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Mayo Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mayo Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mary Lee Jones

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife: ********** 6.(c) If alive, give age: *** years

7. Birth date of deceased (mo., day, yr.): January 31, 1942

8. AGE: Years	Months	Days	If less than one day
3	5	25	..... hrs. ..... min.

9. Birthplace: Mayo A. A. Co. Md. (Town, county, and state)

10. Usual occupation: **********

11. Industry or business: None

FATHER
12. Name: Carroll Jones
13. Birthplace: Mayo Md.

MOTHER
14. Maiden name: Sara Colbert
15. Birthplace: Harwood Md.

16. Informant: Mrs Goldie James
Address: 19 College Ave. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/27/45 (month) (day) (year)
Cemetery or crematory: Mayo Cemetery
Location: Mayo A. A. Co
18. Funeral director: Mrs Chas. O. Hyde
Address: 45 Northwest St Annapolis Md.

19. June 27 19 45 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 19 45 at 2 10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Rocky Mountain Spotted Fever	10 days
Due to: 14 days	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other
Address: Annapolis Md. Date signed: 6/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05722

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Parole, Maryland
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A. Co.
City or town Parole, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Parole, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Thomas H. Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Irene Jones
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1870

8. AGE: Years	Months	Days	If less than one day
75	2	10	hrs. min.

9. Birthplace Davidsonville, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Thomas Jones
13. Birthplace Maryland

MOTHER
14. Maiden name Lucy (unknown)
15. Birthplace Maryland

16. Informant Irene Jones
Address Parole, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22, 1945 (month) (day) (year)
Cemetery or crematory Davidsonville, Md.
Location Davidsonville, Md.

18. Funeral director J.B. Johnson
Address Annapolis, Maryland

19. June 22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1945 at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5/13 1945 to 6/21 1945 and that I last saw h alive on 1945

Immediate cause of death	DURATION
Hypertensive Cardio Vascular Renis	
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Theodore G. Johnson M.D.
M. D. or other
Address 35 Northwest Street Date signed 6/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CB 05726

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long is above place of death?
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Gettysburg, Pa. County: Adams
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 136 Carlisle Street
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: WALLACE JULIUS JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			11 hrs. 10 min.

9. Birthplace: Annapolis, Anne Arundel, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Wallace Julian Johnson
13. Birthplace: Tolley, North Dakota

MOTHER
14. Maiden name: Elizabeth Ida Swope
15. Birthplace: Harrisburg, Penna.

16. Informant: Wallace Julian Johnson, C.A.P.
Address: N.A.F. Middle River, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-7-45 (month) (day) (year)
Cemetery or crematory: U.S.N.A. Cemetery
Location: U.S.N.A. Annapolis, Maryland

18. Funeral director: B.L. Hopping
Address: 170 West St., Annapolis, Md.

19. June 7 19 45 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 19 45 st M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12:50 A.M. 6-6- 19 45, to 12 P.M. 6-6- 19 45
and that I last saw h slive on JUNE 6 19 45

Immediate cause of death	DURATION
IMMATURITY	11 Hr.
Due to: PREMATURE BIRTH	10 Min.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Paul Peterson, Comdr. (MC), USN
M. D. or other
Address: U. S. Naval Hospital, Annapolis, Maryland Date signed: 6- 7- 45

VS A15 (I) (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 05727 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos. 6 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: St. Mary's County

City or town: California
(If outside city or town limits, write RURAL and give nearest town)

Street No. ---------
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Clyde Kane

3. (b) Social Security Number: ---------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

B.(b) Name of husband or wife: unknown

B.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1901

8. AGE: Years	Months	Days	If less than one day
44	unknown		..... hrs. ..... min.

9. Birthplace: St. Mary's County (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: -------

FATHER
12. Name: George Kane
13. Birthplace: Maryland

MOTHER
14. Maiden name: Amy Allens
15. Birthplace: Maryland

16. Informant: Hospitals Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 6-19-45 (month) (day) (year)

Cemetery or crematory: St Johns

Location: Hollywood, Md

18. Funeral director: W. C. Mattingley Sons

Address: Leonardtown, Md.

19. June 15 19 45 (Date rec'd by registrar) E. Joyce Lord Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1945 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1945, to June 16 1945 and that I last saw him alive on June 16 1945

	DURATION
Immediate cause of death: General Paresis	known to us since 4/11/45
Due to:	
Due to:	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings of operations: -------

Date of op.

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of -------

Where did injury occur? ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -------

Means of injury ------- Injured at work? -----

23. SIGNATURE: Fred L. Whitaker M. D. or other

Address: Crownsville, Maryland Date signed: 6/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

05728

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years.

Hospital, institution, or street address where death occurred: Home - 3rd Wood Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Brooklyn Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3513 - IV Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Florence KARCZEWSKI

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

B.(b) Name of husband or wife: Walter J. Karczewski

B.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): January 5th 1902

8. AGE: Years	Months	Days	If less than one day
43	5	6	....hrs. ....min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: Housekeeping.

11. Industry or business:

FATHER — 12. Name: James FILIPIAK

FATHER — 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Antoinette SCHRATER

MOTHER — 15. Birthplace: Germany

18. Informant: Walter J. Karczewski (Husband)

Address: Glen Burnie, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 6/15/45 (month) (day) (year)

Cemetery or crematory: St Stanislaus

Location: Dunalk Ave

18. Funeral director: John J. Duda

Address: 2829 Hudson St.

19. June 13 1945 (Date rec'd by registrar) A. W. Hedrick Registrar

A.E.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1945 at 3 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1944 to June 10 1945 and that I last saw her alive on 6/10/45 1945

Immediate cause of death	DURATION
Heart failure	
Due to: Bronchial Asthma	6 Years
Due to: Pulmonary Edema	3 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gustave A Paukert MD M. D. or other

Address: Glen Burnie Md Date signed: 6/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-G)

05729

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft. George G. Meade,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Regional Hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Indiana County: --
City or town: Vevay
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. # 4
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: Major Harry M. KELLAM

3.(b) Social Security Number: 0-225,583

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marguerite E. Kellam
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): 22 Sept 1890

8. AGE: Years	Months	Days	If less than one day
54	8	13	-- hrs. -- min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: Officer
11. Industry or business: U. S. Army
FATHER 12. Name: Unknown
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Unknown
16. Informant: W.D.,A.G.O. Form #66-1
Address: Officers QualificationCard US Army
17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/4/45 (month) (day) (year)
Cemetery or crematory: Moore's Funeral Home
Location: 34th St. & College Ave. Indianapolis Ind.
18. Funeral director: Howard T. Blight Jr. HOWARD BLIGHT, JR.
Address: 4914 Belair Rd., Baltimore, Md.
19. 4 June (Date rec'd by registrar) 19 45 W.J. Lawson Jr. W.J. LAWSON, JR., 1st Lt. MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 June 19 45, at 2005 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased ~~MDK~~ 3 June 19 45 ~~XXXXXXXXXXXXXXXXXX~~ and that I last saw him alive on 3 June 19 45

Immediate cause of death	DURATION
Thrombosis, Cerebral, right, cause undetermined	11 days
Due to	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: --
Date of op.: --
Autopsy results: Confirmed as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of: --
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --
Means of injury: -- Injured at work? --

23. SIGNATURE: William H. Robinson III MC or other
WILLIAM H. ROBINSON, III, Capt. MC
Address: Reg. Hosp., Ft Meade, Md. Date signed 4 June 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

05730

Reg. Dist. No. 21

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County a a

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County a.a

City or town annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 academy
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George M. Kirby

3.(b) Social Security Number 216-16-4837

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Laura V Kirby

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Oct 13 1881

8. AGE: Years	Months	Days	If less than one day
63			....hrs. ....min.

9. Birthplace Davidsonville. Md
(Town, county, and state)

10. Usual occupation Fireman

11. Industry or business

FATHER
12. Name Floyd Kirby
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah Lee
15. Birthplace Maryland

16. Informant Laura V. Kirby

Address 111 academy St annapolis. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21/45 (month) (day) (year)

Cemetery or crematory All Hallows

Location Birdsville md

18. Funeral director B L. Hopkins

Address annapolis, Md

19. June 20 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19th 1945 at 1 02 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 43 to June 19th 1945 and that I last saw him alive on June 19th 1945

Immediate cause of death	DURATION
acute dilatation of heart, edema of lung	
Due to coronary disease	3 yrs
Due to angina pectoris	
Other conditions arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edith Roller M.D.
M. D. or other

Address 42 State Circle Date signed 6-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

05731

Reg. Dist. No. 20

1. PLACE OF DEATH:
County A.A
City or town Davidsonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A. A.
City or town Davidsonville.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Henry. Kirby

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Louise Kirby
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1868

8. AGE: Years 82 | Months 11 | Days 7 | If less than one day hrs. min.

9. Birthplace Richmond. Virginia
(Town, county, and state)

10. Usual occupation Boiler Maker

11. Industry or business Retired

FATHER
12. Name John Kirby
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Gladys E. Paddy
Address Davidsonville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 18, 1945 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18. Funeral director B.L.Hopping
Address Annapolis, Maryland.

19. June 18 1945 (Date rec'd by registrar) Carrie J. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1945, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1945, to June 14 1945, and that I last saw h- alive on June 14 1945

Immediate cause of death	DURATION
Acute myocardial failure	
Due to Arteriosclerosis senile.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Emily N. Wilson. M.D.
M. D. or other
Address Cottman Md. Date signed 6/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

05732

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A.A.C.

City or town Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 3 weeks.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A.A.

City or town Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 208 - Meadow Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Caroline Kusser.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed.

6.(b) Name of husband or wife Godfred Kusser Sr. (Deceased) 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 15 - 1868.

8. AGE: Years	Months	Days	If less than one day
76	7	14	____ hrs. ____ min.

9. Birthplace Harford, Md. (Town, county, and state)

10. Usual occupation Housekeeping.

11. Industry or business

FATHER 12. Name — Mccall

13. Birthplace Russia.

MOTHER 14. Maiden name ? ?

15. Birthplace Russia.

16. Informant Gustave Kusser (Son)

Address 2517 - W. LaFayette Ave.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 7/2/45 (month) (day) (year)

Cemetery or crematory Cedar Hill cemetery.

Location A.A. County.

18. Funeral director A. Howard Evans.

Address 1400 - S. Charles St. Baltimore 30-

19. June 29 1945 (Date rec'd by registrar) M. Dealba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1945 at 3.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____ to ____ 19____ and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Heart failure	Sudden.
Due to	
Senility.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? No (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gustave A. Kusser MD M. D. or other Medical Examiner.

Address Glen Burnie, Md. Date signed 6/29/45

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05733

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fairview Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Few hours.
Hospital, Institution or street address where death occurred: Rock Creek
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2619 - Guantlet Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Meyer Kreof

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 20 - 1916

8. AGE: Years: 29 | Months: 1 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Hazleton - Penn.
(Town, county, and state)

10. Usual occupation: Ship yard worker -

11. Industry or business:

MOTHER
12. Name: Israel Kreof
13. Birthplace: Russia.

FATHER
14. Maiden name: Leah Baden
15. Birthplace: Russia

16. Informant: Lou Kreof (brother)
Address: 117 - N. White st. - Shenandoah

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6-26-45 (month) (day) (year)
Cemetery or crematory: Shenadoah, Penna.
Location:

18. Funeral director: Jack Heins Inc
Address: 1439 E. Balto St

19. 6/26 (Date rec'd by registrar) 45 D.W. Hendrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19— to — 19—
and that I last saw h— alive on — 19—

Immediate cause of death	DURATION
accidental drowning	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 6/24/45
Where did injury occur? Rock creek (City or town) Anne Arundel (County) Md. (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Gustave H. Pauter M.D. acting med. examiner M. D. or other
Address: Glen Burnie Md Date signed 6/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-A)

05734

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glenburnie Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Aa

City or town: Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Glenburnie Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ernestine Hollie Kraus

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

B.(b) Name of husband or wife: Henry Kraus

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 20 - 1893.

8. AGE: Years	Months	Days	If less than one day
52	1	12	hrs. min.

9. Birthplace: Bato Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Godfrey Eskeway

FATHER 13. Birthplace

MOTHER 14. Maiden name: Caroline ?

MOTHER 15. Birthplace: Germany

16. Informant: Geo Kraus

Address: Glen Burnie Md

17. (Burial, cremation, or removal. Which?) Date thereof 6-5-45 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Brooklyn Park Md

18. Funeral director: Samuel L. McCurley

Address: 130 E. First Ave.

19. June 4 1945 (Date rec'd by registrar) A. W. Hedrick Registrar

A.T.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2 - 45 19 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 - 45 to June 2 - 45 19

and that I last saw h[illegible] alive on June 1 - 45 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to	
Due to	
Other conditions Arteriosclerosis Hypertension (contrib.)	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. Lipsky M. D. or other

Address: Glen Burnie Md Date signed: June 2 - 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 05735

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: B. C. W.

City or town: Orchard Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred: Cliff Place

How long in hospital or institution? 1 yr.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ..... County: .....

City or town: .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME Ellen Cecelia Lamont

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Samuel James Lamont. 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 28, 1881

8. AGE:

Years	Months	Days	If less than one day
64			..... hrs. ..... min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual occupation: Housework.

11. Industry or business: .....

FATHER

12. Name: James Brophy

13. Birthplace: Ireland

MOTHER

14. Maiden name: Sarah Kiely

15. Birthplace: Ireland

16. Informant: Mrs. Sarah E. Fowler

Address: Orchard Beach Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-3-45 (month) (day) (year)

Cemetery or crematory: Cemetery Catholic

Location: Baltimore Md.

19. Funeral director: Flynn & Fleming

Address: 1410 Light St

19. 7/6 19 45 [signature] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 19 45 at 7.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 19 45 to June 30 19 45 and that I last saw h.... alive on June 29 - 19 45

Immediate cause of death: Acute myocarditis

DURATION: One week

Due to: Paralysis Hemiplegia

DURATION: One years

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Thos. H Phillips M. D. or other

Address 1939 Edmondson Ave. Date signed July 1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

05736

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ferndale Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Ferndale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 101 Ferndale Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ethel D. Meyers

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles W Meyers
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): November 20, 1886

8. AGE:

Years	Months	Days	If less than one day
58	7	6	...hrs. ...min.

9. Birthplace: Bangor Pa (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Own Home
FATHER 12. Name: John Jones
13. Birthplace: Wales
MOTHER 14. Maiden name: Elizabeth Williams
15. Birthplace: Oshkosh Wis
16. Informant: Mr. Charles W. Meyers
Address: Ferndale, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 29 1945 (month) (day) (year)
Cemetery or crematory: Lorraine
Location: Balto. Md
18. Funeral director: Thomas W. Creighton
Address: Glen Burnie, Md.
19. June 29 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1945, at 2:05 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 24-45 to June 26-45 19...
and that I last saw h... alive on June 26-45 19...

Immediate cause of death	DURATION
Cerebral Thrombosis	1 day
Due to	
Due to	
Other conditions: Malignant Hearts.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed: June 28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Item 3. Film G143 6/19/52-2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-O)

CERTIFICATE OF DEATH

05737

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? I8 Clay Street
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: I8 Clay Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Albert Mobray

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Claude Mobray
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. I9, I892

8. AGE: Years	Months	Days	If less than one day
52	9		hrs. min.

9. Birthplace: Annapolis, Md. (Town, county, and state)
10. Usual occupation: U.S.N.N.A. Utility
11. Industry or business:

FATHER
12. Name: John Mobray
13. Birthplace: Md.

MOTHER
14. Maiden name: Sarah Dockins
15. Birthplace: Md.

16. Informant: Claude Mobray.
Address: 30 Washington St., Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22, I945 (month) (day) (year)
Cemetery or crematory: National Cemetery
Location: Annapolis, Md.

18. Funeral director: J.B. Johnson.
Address: Annapolis, Md.

19. June 22 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/18 19 45, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3, 19 44, to June 18 19 45
and that I last saw him alive on June 18, 19 45

	DURATION
Immediate cause of death: Cerebral Accident	
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Theodore F. Johnson M.d. M. D. or other
Address: 35 Northwest Street Date signed: 6/20/45

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

015738

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 12 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 year, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 62 Park Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: NICHOLS - EDWARD

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Mary Nichols, 620, W. Mulberry St., Balto. Md. 6.(c) If alive, give age: unk years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years	Months	Days	If less than one day
61	unknown		--- hrs. --- min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -------

FATHER
12. Name: Sam Nichols
13. Birthplace: Virginia

MOTHER
14. Maiden name: Carrie Donkon
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17, 45 (month) (day) (year)

Cemetery or crematory: Wrough Cem.
Location: Wrough Cem.

18. Funeral director: H. M. St. Clair and Son
Address: Cambridge Md

19. June 16 1945 E. 7 Joyce Corse
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13 1945 at 9:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1944 to June 13 1945 and that I last saw him alive on June 13 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 6/20/44
Due to: ----------	
Due to: ----------	
Other conditions: ----------	

(Include pregnancy within 3 months of death)

Major findings of operations: ----------
Date of op.: --------
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: --------
Where did injury occur? --------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: --------- Injured at work? -----

23. SIGNATURE: Edward L. Stutevoss M. D. or other
Address: Crownsville, Maryland Date signed: 6/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (mc)

T 05739

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 1 hour
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? about 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4900 - W - St. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Robert Parker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): Aug. 20, 1916

8. AGE: Years: 28 | Months: 9 | Days: 13 | If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Brakeman
11. Industry or business: Pennsylvania R-R.

FATHER
12. Name: William Parker
13. Birthplace: Rochester, N.Y.

MOTHER
14. Maiden name: Mary E Cloman
15. Birthplace: Newport Del

16. Informant: Mrs. Virginia B Parker
Address: 4900 W-St. S.E. Washington D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: June 4 1945 (month) (day) (year)
Cemetery or crematory: Washington, D.C.
Location:
18. Funeral director: W. W. Chambers Co.
Address: Washington, D.C.
19. June 4 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1945, at M

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination June 3, 1945

Immediate cause of death	DURATION
Fracture of Skull	1½ hrs
Due to: Automobile accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 6/3/45
Where did injury occur? Mayo (City or town) Anne Arundel (County) Md. (State)
Injured at home, farm, industry, public place (where?): Mayo Road
Means of injury: overturned auto Injured at work? no

23. SIGNATURE: John M. Caffey M.D. Deputy medical Examiner
Address: Annapolis, Md. Date signed: 6/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05740 21
Reg. Diat. No.

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since June 12/45
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? June 12/45 to June 20/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Emma Cecelia Phelps

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband ~~or wife~~: Clarence M. Phelps
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Feb 8th 1899

8. AGE:

Years	Months	Days	If less than one day
46	4	12	hrs. min.

9. Birthplace: Washington D.C.
(Town, county and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Wm Sands Downey
13. Birthplace: Odenton Md

MOTHER
14. Maiden name: Hester E. Batchelor
15. Birthplace: Balto Md

16. Informant: Clarence M. Phelps
Address: Odenton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 23-1945 (month) (day) (year)
Cemetery or crematory: Nichols Memorial Church Cem
Location: Odenton Md
18. Funeral director: Pratt & Stricker & B.M. Walters
Address: Pratt & Stricker Sts

19. 6/22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 1945 at 9.08 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12 1945 to June 20 1945
and that I last saw h... alive on June 20 1945

Immediate cause of death	DURATION
Uraemia	24 hrs
Due to: Cardio Vascular failure	about 3 mos
Due to: Nephritis with dilatation	6 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Oliver Turvin M. D. or other
Address: Annapolis, Md. Date signed 6/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-C)

05741

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Annapolis Parole, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Louise Philipps

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Richard Phillips

7. Birth date of deceased (mo., day, yr.): 1883

6.(c) If alive, give age: years

8. AGE: Years	Months	Days	If less than one day
62			hrs. min.

9. Birthplace: West River, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Richard Philipps
Address: Parole, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 11, 1945 (month) (day) (year)

Cemetery or crematory: Churchton

Location: Churchton, Md.

18. Funeral director: J.E.Johnson

Address: Annapolis, Md.

19. June 11 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8, 1945 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28, 1945 to June 8 1945 and that I last saw h[illegible] alive on June 8 1945

Immediate cause of death: Pulmonary Embolism

Not due to cancer. Cut R.

Due to: Pelvic Adhesions

DURATION: Several Mos. Final May 28, 1945

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gilbert R. Anderson M.D.
M. D. or other

Address: Annapolis, Md. Date signed 6/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24a)

CERTIFICATE OF DEATH

05742

Reg. Diat. No. 20

1. PLACE OF DEATH:

County A A.

City or town West River Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A A.

City or town West River.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Edward Phipps

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) oct 12 1943

8. AGE: Years	Months	Days	If less than one day
1	8	12	..... hrs. ..... min.

9. Birthplace West River, AA. Co. Md.

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Spencer Alphonso Phipps

13. Birthplace West River. Md.

MOTHER 14. Maiden name IRIS LORRAINE COLLINSON

15. Birthplace Deale, Md.

16. Informant MRS IRIS L. PHIPPS

Address West River. Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof June 26, 1945 (month) (day) (year)

Cemetery or crematory Catholic (St Mary's)

Location West River. Md.

18. Funeral director T. A. Hardesty & Son

Address Galesville Md.

19. 6/25 19 45 H. R. Clayton by mail Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 19 45 at 12 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 12, 19 43 to June 24 19 45

and that I last saw him alive on June 23, 19 45

Immediate cause of death 2 day Sick's Disease — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Emily A. Wilson, M.D. M. D. or other

Address Lothian, Md. Date signed 6/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176-C)

CERTIFICATE OF DEATH

05743

Reg. Dist. No. 21

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: A. A.
City or town: Orchard Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Balto City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3462 Childs Court
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Charles Owen Pilley

3. (b) Social Security Number: 239-285-845

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 29 1923

8. AGE: Years	Months	Days	If less than one day
21	9	13	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Ship Yard Rigger
11. Industry or business:
FATHER 12. Name: Charles Pilley
13. Birthplace: N. C.
MOTHER 14. Maiden name: Josephine Harris
15. Birthplace: N. C.
16. Informant: Josephine Harris
Address: 3462 Childs Court
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13, 45 (month) (day) (year)
Cemetery or crematory: Glen Heaven
Location: Riche Highway
18. Funeral director: Martin J. Connor
Address: 1600 N. Hollins
19. June 12 19 45 (Date rec'd by registrar) McCabe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 19 45, at 1 40 A M
21. I CERTIFY that death occurred on the date above stated; [redacted] from
19, to 19
a [redacted] 19

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 6/11/45
Where did injury occur? near Orchard Beach (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Stony Creek
Means of injury: Auto plunged in Creek Injured at work? No.

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
Address: Annapolis Md. Date signed 6/11/45

T 05744

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:
Regional Hospital

How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Mississippi County: ---

City or town: West Point
(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 E. Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: Roger W. PRYOR

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 14 July 1926

8. AGE: Years	Months	Days	If less than one day
18	10	21	- hrs. - min.

9. Birthplace: West Point, Mississippi
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Sarah (Unknown) PRYOR

MOTHER — 15. Birthplace: Unknown

16. Informant: Service Record

Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/4/45 (month) (day) (year)

Cemetery or crematory: Calvert Furniture Co.

Location: West Point, Miss.

18. Funeral director: Howard M. Blight Jr. HOWARD BLIGHT, JR.

Address: 4914 Belair Rd., Baltimore, Md.

19. 4 June 19 45 (Date rec'd by registrar) W J Lawson Jr. W.J.LAWSON, JR., 1st Lt. MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 June 19 45 at 6:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~DOC~~
3 June 19 45 ~~xxxxxxxxxxxxxxxxxxxxx~~
and that I last saw him alive on 3 June 19 45

Immediate cause of death: Multiple abscesses of peritoneal cavity with extension: right subdiaphragmatic, left ~~xxxx~~ subdiaphramatic with perforation of left dome of diaphragm and enpyema. Pulmonary atelectasis. Due to: acute appendicitis.

DURATION

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Appendicitis, acute suppurative Date of op. 11 May 45

Autopsy results: Confirmed as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: --

Where did injury occur? --
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: S. D. Hoeper 1st Lt. M. D. or other MC
S. D. HOEPER, 1st Lt.

Address: Regional Hospital Ft. Meade Md. Date signed 4 June 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

3723 Liberty Hgts

Evidence for change of birth date of deceased is shown on FILM No. G96

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

BC 05745 P

JUL 10 1945

Reg. Dist. No.

1. PLACE OF DEATH:
County: Maryland Anne Arundel
City or town: Brooklyn
(If outside city of town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Balto - Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1109 S. Streeper St
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Marya Radecka

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Jacob Radecke
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Sept 29 - 1867 1877

8. AGE: Years	Months	Days	If less than one day
67	8	3	hrs. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business
FATHER — 12. Name: Joseph Ludzik
13. Birthplace: Poland
MOTHER — 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Joseph Radecke
Address: 3720 Brooklyn Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5-45 (month) (day) (year)
Cemetery or crematory: Saint Stanislaus
Location: Balto. Md.
18. Funeral director: John J. Duda
Address: 2829 Hudson Street
19. 6/4 45 DW Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1945, at 11:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 1945, to May 31 1945
and that I last saw h[illegible] alive on May 31 1945

Immediate cause of death	DURATION
Due to: Cerebral sclerosis	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Samuel Rubin M.D. M. D. or other
Address: 203 Pulaski Hwy Date signed: 6/3/45

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING (1)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05746

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A A
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 194 West St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Theodore W. Robertson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jany 8th 1944

8. AGE: Years: 1 Months: 7 Days: 19 If less than one day: hrs. min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Sigurd W. Robertson
13. Birthplace: Norway

MOTHER
14. Maiden name: Louise Taylor
15. Birthplace: Portsmouth Va

16. Informant: Sigurd W. Robertson
Address: 194 West St. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 29th 1945 (month) (day) (year)
Cemetery or crematory: Cedar Bluff Cemt
Location: Annapolis Md

18. Funeral director: John W. Taylor
Address: Annapolis Md

19. June 29 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24 1945 to June 27 1945 and that I last saw h.i. alive on June 27 1945

Immediate cause of death	DURATION
Lobar pneumonia	4 days
Due to	
Due to	
Other conditions: Hydrocephalus.	some with

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: I Bosworth MD
M. D. or other
Address: Annapolis Md Date signed: 6/28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

05747

Reg. Dist. No. 44

P.F. Co. ~~Baltimore Co.~~

1. PLACE OF DEATH:

County Oakleigh Beach

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County

City or town Balto.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 Warren Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas Edward Sanford Jr.

3.(b) Social Security Number 219-18-4728

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16-1927

8. AGE: Years 18 | Months | Days | If less than one day hrs. min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business Md. Drydock

FATHER 12. Name Thomas Edward Sanford Sr.

FATHER 13. Birthplace Md

MOTHER 14. Maiden name Mildred Anna Boldy

MOTHER 15. Birthplace Md.

16. Informant Mr. Thomas Sanford Sr.

Address 103 Warren Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/27/45 (month) (day) (year)

Cemetery or crematory Glen Haven

Location Annapolis Blvd.

18. Funeral director John F. Penny Inc.

Address 715 Light St.

19. 6/27/ 19 45 John B Connelly

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1945, at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Drowning	Instant
Due to (a) accidental	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/24/45

Where did injury occur? Maerney Balto Md

(City or town) Oakleigh Beach (County) (State)

Injured at home, farm, industry, public place (where?) Public Beach

Means of injury Drowning Injured at work? No

23. SIGNATURE T McSweeney M.D.

Deputy Medical Examiner

Address Brooklyn Md. Date signed 6/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

T05748

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Best Gate
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Best Gates
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: DANIEL SIMON.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary E. Simon
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): 1861

8. AGE: Years: 84 | Months | Days | If less than one day: ... hrs. ... min.

9. Birthplace: West River Md.
(Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business

FATHER
12. Name: Charles Simon
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary E ~~Harris~~ Scott
15. Birthplace: Unknown

16. Informant: Mary E. Harris
Address: Best Gates

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: June 13 1945
(month) (day) (year)
Cemetery or crematory: Fowlers Cem.
Location: Best Gates Md

18. Funeral director: F. C. Hardesty & Son.
Address: Galesville Md

19. June 12 19 45
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1945 at 8 00 P.M.

21. I CERTIFY that death occurred on the date above stated. ~~Last attended deceased~~ Post mortem Examination ~~Saw deceased~~ June 11 1945

Immediate cause of death	DURATION
Acute Myocarditis	unknown
Due to: General Astero-sclerosis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffy M.D. Deputy Medical Examiner
Address: Annapolis, Md. Date signed: 6/11/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

05749

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co. Md
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 95 Cathedral
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME: Lorid F. Small

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 9 1874

8. AGE: Years 71 | Months 3 | Days 17 | If less than one day: hrs. min.

9. Birthplace: Annapolis Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: James Small
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Myers
15. Birthplace: Maryland

16. Informant: Elvira A Myers
Address: Woodland Ave Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 5/45 (month) (day) (year)
Cemetery or crematory: St Anne's
Location: Annapolis Md

18. Funeral director: B. L. Hopkins
Address: Annapolis Md

19. June 5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2, 1945, at 6:00a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1945, to June 2, 1945
and that I last saw h... alive on June 2, 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 days.
Due to: Arteriosclerosis	5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Albert R Anderson M.D. M. D. or other
Address: Annapolis Md Date signed: 6/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

05750

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A.

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 25 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A.

City or town Weems Creek

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war Spanish American War

3. (a) FULL NAME Daniel S. Sowers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Harriet G. Sowers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 8 — 1869

8. AGE: Years	Months	Days	If less than one day
76	5	12	..... hrs. ..... min.

9. Birthplace Schenectady, New York

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Michael Sowers

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant John T. Sowers

Address R.F.D. 3. Box 790a, Annapolis Md

17. Remove (Burial, cremation, or removal. Which?) Date thereof June 21/45 (month) (day) (year)

Cemetery or crematory

Location Schenectady New York

18. Funeral director B. T. Hopkins

Address Annapolis Md

19. June 21 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 45, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1 19 45, to June 20 19 45

and that I last saw him alive on June 20 19 45

Immediate cause of death	DURATION
Carcinoma Rectum & pelvic Bones	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Basil M. D. or other

Address Annapolis Md Date signed 6-20-45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

05751

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Curtis Bay, 26

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Outdoors

Hospital, Institution, or street address where death occurred: Stoney Beach.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 653 - E. Clement St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Lillian Mae Spicer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 2 - 1930

8. AGE: Years: 14 | Months: 11 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: school girl

11. Industry or business:

FATHER — 12. Name: Harry B. Spicer

13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Lillian May Finan

15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Harry B. Spicer (Father) Address: 653 - E. Clement St. - Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 27-1945 (month) (day) (year)

Cemetery or crematory: Holy Cross

Location: A. A. Co. Md.

18. Funeral director: Flynn & Fleming

Address: 1476 Light St.

19. 6/27 1945 (Date rec'd by registrar) C. W. Aldrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death: accidental Drowning.	Sudden
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident. Date of: 6/24/45

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Patapsco River.

Means of injury: Drowning. Injured at work? No

23. SIGNATURE: Gustave A. Faubert M. D. (M. D. or other)

Address: Glen Burnie Date signed: 6/27/45

Accidental Drowning

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

BC 05752

★ Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: Glen Haven

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Few hours

Hospital, Institution, or street address where death occurred: Stoney Creek.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 356 - South Smallwood.

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Arthur Clifford Spitler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9/6/26

8. AGE:

Years	Months	Days	If less than one day
18	9	11	hrs. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Automobile mechanic.

11. Industry or business:

FATHER

12. Name: Arthur F. Spitler

13. Birthplace: Virginia

MOTHER

14. Maiden name: Bessie L. Huff.

15. Birthplace: West Virginia

16. Informant: Mrs. A. F. Spitler (mother)

Address: 356 - S. Smallwood St. - Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 20-1945 (month) (day) (year)

Cemetery or crematory:

Location: Martinsburg W Va

18. Funeral director: Pratt C. B. M. Walters

Address: Pratt & Stricker Sts

19. (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 19 45 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Accidental drowning	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident. Date of 6/17/45

Where did injury occur? Glen Haven (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Stoney Creek.

Means of injury: Injured at work?

23. SIGNATURE: Clifford A. Pantenburg M.D. attending medical (M. D. or other)

Address: Glen Burnie, Md. Date signed 6/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

D 05753

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A. Co.

City or town Linthicum Hgts.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yr.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County AA

City or town Linthicum Hgts.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 408 Forest View Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Augusta Stenka

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife August Stenka

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 9 of 1857

8. AGE: Years 87 | Months 9 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name JOSEPH. KOHNKE

13. Birthplace GERMANY.

MOTHER 14. Maiden name MARY. A ROVINAS

15. Birthplace GERMANY

16. Informant MRS PHILIP H DAVIS

Address 408 FOREST. VIEW AVE

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 6-5-45 (month) (day) (year)

Cemetery or crematory HOLY CROSS CEM.

Location A.A.Co

18. Funeral director Bernard C Harle

Address 121 E. West St

19. 6/4 1945 Ella Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1945, to June 2 1945

and that I last saw h alive on June 2 1945

	DURATION
Immediate cause of death Cerebral Hemorrhage	1 week
Due to Cardio Vascular Disease	10 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr. M.D.
M.D. or other

Address Linthicum Date signed June 2-1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

105754

★

Reg. Diat. No. 23

1. PLACE OF DEATH

County: Anne Arundel

City or town: Big Ditch (Ireland)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? two hours

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1209 N. Highland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Joseph Francis Sullivan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Catherine Sullivan

Nee Casey 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): December 22, 1881

8. AGE:

Years	Months	Days	If less than one day
63	7	2	____ hrs. ____ min.

9. Birthplace: County Clare Ireland
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: odd jobs

FATHER
12. Name: Unknown
13. Birthplace: Ireland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Ireland

16. Informant: Joseph F. Sullivan

Address: 6 Irving Place, Palmer Heights Md.

17. Receiving Vault (Burial, cremation, or removal. Which?) Date thereof June 27-1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cemetery

Location: Anne Arundel Co.

16. Funeral director: Thomas W. Singleton

Address: Glen Burnie Md.

19. June 27 1945 (Date rec'd by registrar) M. A. Allen Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945, at 12:01 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____, 19____, to ____, 19____

and that I last saw h____ alive on ____, 19____

	DURATION
Immediate cause of death: accidental drowning	Instant.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 6/24/45

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Magothy River

Means of injury: ____ Injured at work?

23. SIGNATURE: Gustave A. Rawlen M.D. M. D. or other

Address: Glen Burnie Md. Date signed 6/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

05755

CERTIFICATE OF DEATH

Reg. Dist. No. 2 1

1. PLACE OF DEATH:
County Anne Arundel
City or town Ferndale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Ferndale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma M. Taylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife late Howard Taylor
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1868

8. AGE: Years	Months	Days	If less than one day
76			..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Abrams
13. Birthplace —

MOTHER
14. Maiden name —
15. Birthplace —

16. Informant Mr. J. Frank Cole
Address Ferndale Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 6-18-45
(month) (day) (year)
Cemetery or crematory Hopewell Cem.
Location Cecil Co. Md

18. Funeral director Harry H. Wyke
Address 4101 E Monument Ave.

19. 6/18/45 A. W. Fedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May. 1938, to June 15 1945
and that I last saw h.. alive on June 15 1945

Immediate cause of death	DURATION
Cardio-Vascular Disease	4 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball M. D.
M. D. or other
Address Linthicum Date signed 6-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

05756

CERTIFICATE OF DEATH ★

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 16 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: East New Market
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3. (a) FULL NAME

THOMPSON - MAGGIE

3. (b) Social Security Number

---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

B.(b) Name of husband or wife: ----

---- 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) ----

8. AGE: Years	Months	Days	If less than one day
46			____ hrs. ____ min.

9. Birthplace: Dorchester County, Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Fred Thompson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Henrietta Ross
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 7/11/45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt

Address

19. July 11 1945 (Date rec'd by registrar) E T Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28, 1945, at 7:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4 1945, to June 28 1945 and that I last saw her alive on June 28 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Since 1/4/45
Due to	
Due to	
Other conditions: Psychosis with Mental Deficiency (Include pregnancy within 3 months of death)	

Major findings of operations: ----

---- Date of op. ---

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of ---

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury ---- Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

05757

Reg. Dist. No. 26.

1. PLACE OF DEATH:
County Anne ARUNDEL
City or town Shadyside Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 81 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A A
City or town Shadyside, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME John TURNER

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Widowed.

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 26 1863

8. AGE: Years	Months	Days	If less than one day
81	7	8	hrs. min.

9. Birthplace Shadyside AA. Co. Md.
(Town, county, and state)
10. Usual occupation Oysterman
11. Industry or business Sea food.
FATHER 12. Name John TURNER
13. Birthplace Baltimore City, Md.
MOTHER 14. Maiden name Julia Mack.
15. Birthplace Shadyside. Md.
16. Informant HERMAN NICK
Address Shadyside Md.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof June 9 1945 (month) (day) (year)
Cemetery or crematory St Matthews
Location Shady Side
18. Funeral director C. A. Gaudy & Son
Address Galesville Md.
19. June 9 1945 J. B. Dent
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 1945 at 6 30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I last saw [redacted] alive on June 7, 1945
Post mortem Examination Findings

Immediate cause of death	DURATION
Chronic myocarditis	uncertain
Due to: General Arterio-Sclerosis	uncertain
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

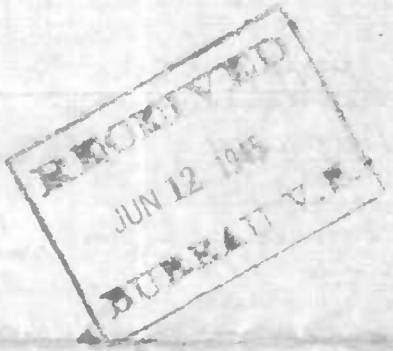
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John N. Cathy M.D. Deputy Medical Examiner
Address Annapolis Md. Date signed 6-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 21

(5758 P

1. PLACE OF DEATH:

County: Anne Arundel

City or town: near Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 704 Bartlett Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Gerard Fuhl Uhl

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 1930

8. AGE: Years	Months	Days	If less than one day
15			hrs. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation: School

11. Industry or business:

FATHER
12. Name: Adam Uhl
13. Birthplace: Maryland

MOTHER
14. Maiden name: Agnes Forster
15. Birthplace: Maryland

16. Informant: Mrs. E. Uhl

Address: 704 Bartlett Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-21-1945 (month) (day) (year)

Cemetery or crematory: Cathedral Cemetery

Location:

18. Funeral director: Mary M Kuebler

Address: 501 E 22nd Sts

19. 6/19/45 (Date rec'd by registrar) A.W. Hidrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17 1945 at 1 07 P.M.

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination

and that I last attended deceased on June 17 1945

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 6/17/45

Where did injury occur? near Annapolis A.R. Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Mill Creek

Means of injury Drowning Injured at work? no

23. SIGNATURE: John M. Cathey M.D. Deputy Medical Examiner

Address: Annapolis Md Date signed 6/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

7/

7512
260
353

Vault –
casket
Mary Theresa

5th/61/9

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

T 05759

CERTIFICATE OF DEATH

Reg. Diot. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 118 Prince George St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Malcolm Watson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Caroline E. Watson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jany 19th 1860

8. AGE:

Years	Months	Days	If less than one day
85	4	15	hrs. min.

9. Birthplace: A. A. Co. Md (Town, county, and state)
10. Usual occupation: Retired Merchant Butcher
11. Industry or business:

FATHER
12. Name: Thomas E. Watson
13. Birthplace: A A Co Md

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Mrs James T Small
Address: Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 5th 1945 (month) (day) (year)
Cemetery or crematory: St Annes Cemetery
Location: Annapolis Md
18. Funeral director: John W Taylor Sons
Address: Annapolis Md.

19. June 4 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1945, at 2 30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 20 1945 to June 3 1945
and that I last saw him alive on June 2 1945

Immediate cause of death	DURATION
Myocarditis Chr.	unkn
Myocardial Insufficiency	unkn
Due to	
Due to	
Other conditions Arteriosclerosis	unkn

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Boul, M. D. or other
Address: Annapolis Md Date signed: 6-3-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161)

CERTIFICATE OF DEATH

05760

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ft. Geo. G. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months.

Hospital, institution, or street address where death occurred:
Regional Hospital

How long in hospital or institution? 6 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Virginia County: —

City or town: Marianna
(If outside city or town limits, write RURAL and give nearest town)

Street No.: —
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Alvin R. WEBB

3.(b) Social Security Number: 35,441,841

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 8 January 1921

8. AGE: Years	Months	Days	If less than one day
24	5	1	— hrs. — min.

9. Birthplace: Pineville, W. Va.
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U.S. Army

FATHER — 12. Name: Frank Webb

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Nellie (Unknown) Webb

MOTHER — 15. Birthplace: Unknown

16. Informant: Service Record

Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof 6/11/45 (month) (day) (year)

Cemetery or crematory: Robertson & Foglesong

Location: Mullens West Va

19. Funeral director: Howard H. Blight Jr.

Address: 4914 Belair Rd. Baltimore, Md. HOWARD BLIGHT, JR.

19. (Date rec'd by registrar) 10 June 19 45 W. J. Lawson Jr.
W.J.LAWSON,JR., 1st Lt. Registrar
MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 June 19 45 at 5:01P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 9 June 19 45

Immediate cause of death	DURATION
Pulmonary edema	
and pleural effusion	
Due to: massive, Bilat	
edema,	
Due to: Burns: 1st 2nd	
Other conditions: 3rd degree burns	
25% body surface	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: Confirmed as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 4 June 45

Where did injury occur? Range Ft Geo. G. Meade, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Flame Thrower Range

Means of injury: Flame Thrower Injured at work? Yes.

E. L. Waisbrot

23. SIGNATURE: E.L.WAISBROT, Major, MC

Address: Regional Hosp Ft Meade, Md Date signed: 11 Jun 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

05763

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Dorsey
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Glen Burnie Box 176
(If outside city or town limits, write RURAL and give nearest town)
Street No. Dorsey Road Near West Port Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Robert Lee Whay Sr.

3.(b) Social Security Number UNKNOWN.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	white.	Married

6.(b) Name of husband or wife: Mary M. Whay
6.(c) If alive, give age: 68 years
7. Birth date of deceased (mo., day, yr.): March 1, 1870

8. AGE:

Years	Months	Days	If less than one day
75	3	10	...hrs. ...min.

9. Birthplace: Litwatey Lancastey Co. Va.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: John Whay
13. Birthplace: Virginia

MOTHER
14. Maiden name: Liza Whay
15. Birthplace: Lancaster Co Va

16. Informant: R. Randolph Whay
Address: Glen Burnie Md-Box 176

17. Burial (Burial, cremation, or removal, Which?) Date thereof: June 15 1945 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: Cedar Hill A.A. Co. Md
18. Funeral director: Thomas W Singleton
Address: Glen Burnie, Md
19. June 15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1945, at 2 45 P.M.
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem & Examination
and that I last saw h... alive on June 10 1945

Immediate cause of death	DURATION
Acute Dilatation of Heart	Sudden
Due to: Chronic Myocarditis	uncertain
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Cathey M.D. Deputy Medical Examiner
M.D. or other
Address: Annapolis Md Date signed: 6/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (W)

05764

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
County Anne Arundel
City or town St. Margaret's
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town St. Margaret's
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward T. Whittington

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Anna R. Whittington
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1874

8. AGE: Years	Months	Days	If less than one day
71	4		..... hrs. ..... min.

9. Birthplace Anne Arundel Co.
(Town, county, and state)
10. Usual occupation farmer
11. Industry or business

FATHER
12. Name Alexander Whittington
13. Birthplace Anne Arundel Co

MOTHER
14. Maiden name unknown
15. Birthplace

16. Informant Mrs. E. T. Whittington
Address St. Margaret's A.A.Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 1945 (month) (day) (year)
Cemetery or crematory St. Margs
Location Annapolis Md
18. Funeral director John W. Taylor
Address Annapolis Md

19. June 12 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945 at 5.00 P.M.

21. I CERTIFY that death occurred on the date above stated. ~~Attended deceased from~~ Last seen alive on June 9, 1945

Post mortem Examination revealed

	DURATION
Immediate cause of death Acute dilatation of Heart	
Due to Chronic myocarditis	
Due to Diabetes mellitus	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address Annapolis, Md. Date signed 6/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

F 05761

Reg. Diat. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. State Circle

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frances Elizabeth Wiegard

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1891

8. AGE: Years	Months	Days	If less than one day
54	2	6	hrs. min.

9. Birthplace Annapolis Md. (Town, county, and state)

10. Usual occupation Retired 3 years

11. Industry or business

FATHER 12. Name Bernard Wiegard

13. Birthplace Germany

MOTHER 14. Maiden name Amelia Robeck

15. Birthplace Annapolis Md.

16. Informant Mrs Catherine M Wiegard

Address Annapolis Md Rt

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 1945 (mouth) (day) (year)

Cemetery or crematory St Marys

Location Annapolis Md.

18. Funeral director John M Taylor

Address Annapolis Md

19. June 12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1945 to June 9 1945

and that I last saw h alive on June 9 1945

Immediate cause of death	DURATION
Myocardial failure	2 mos
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boul M. D. or other

Address Annapolis Md Date signed 6-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

T 05762

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 1 day
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Glendale
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: WILLIAMS - ALBERT

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1897

8. AGE: Years	Months	Days	If less than one day
48	unknown		--- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Ida Murray (?) Snowden
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 5, 1945 (month) (day) (year)
Cemetery or crematory: Brooklyn
Location: Glendale, Prince George County
18. Funeral director: J. Clarence Forcade
Address: Mitchellville, Md.
19. 6/3/45 (Date rec'd by registrar) E. Joyce Forcade Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2, 1945, at 7:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31, 1945, to June 2, 1945 and that I last saw him alive on June 2, 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 3/31/45
Due to: ---	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: J. Clarence Forcade M. D. or other
Address: Crownsville, Maryland Date signed: 6/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

CERTIFICATE OF DEATH

05765

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel Co
City or town Hanover
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Hanover
(If outside city or town limits, write RURAL and give nearest town)
Street No. Stony Run Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mollie Hinks

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John L.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Oct 19. 1870

8. AGE:

Years	Months	Days	If less than one day
74	7	20	..... hrs. ..... min.

9. Birthplace Georgia Ga (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name William L Corder
13. Birthplace Ga

MOTHER
14. Maiden name Jane Low
15. Birthplace Ga

16. Informant John L Hinks
Address Stony Run Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/14/45 (month) (day) (year)
Cemetery or crematory Brookville Cem
Location Kingsville Md
18. Funeral director Williams Funeral Home
Address 127 E Fayette

19. 6/12 19 45 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1945, at 11:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/12/45 19 to 6/9/45 19
and that I last saw h[illegible] alive on 6/9/45 19

Immediate cause of death	DURATION
Due to Carcinoma of Uterus	Approx 1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J Campanella M. D. or other
Address Glen Burnie Date signed 6/14/45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (1) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH

05766

Reg. Diat. No. 25

1. PLACE OF DEATH:

County A.A.Co.

City or town Curtis Bay,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A.A.Co.

City or town Curtis Bay,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4900 Curtis Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME August Wolfe. Jr.

3. (b) Social Security Number 215-01-2673

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) March 15, 1901

8. AGE: Years 44 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Boiler Maker

11. Industry or business

FATHER 12. Name August Wolfe

13. Birthplace Md.

MOTHER 14. Maiden name Elizabeth Martin

15. Birthplace Md.

16. Informant Mrs Edith Vaetl

Address 4221 Morrison Court

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/4/45 (month) (day) (year)

Cemetery or crematory Balto. National

Location Frederick Ave

18. Funeral director John F Henry Inc.

Address 45 Light St.

19. 6/4 1945 (Date rec'd by registrar) Geo. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/1/45 19 ... at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1944 to June 23 1945

and that I last saw h... alive on June 23 1945

	DURATION
Immediate cause of death Cerebral Hemorrhage	Sudden
Due to Hypertension	Yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Geo. D. Hedrick M.D.
M.D. or other

Address 4700 Pennington Ave Date signed 6/3/45

1945-
1899
44

1945
44
1901

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

+05767

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: West Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewborn iofants give residence of mother)
State: Md. County: A.A.
City or town: West Annapolis
(If outside city or towo limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John Henry Wood

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Lillie Wood
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE:

Years	Months	Days	If less than one day
68			..... hrs. ..... min.

9. Birthplace: Ent Hammy Cal Co. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business

FATHER
12. Name: John P. Wood
13. Birthplace: Cal Co

MOTHER
14. Maiden name: Sarah Ann Griffith
15. Birthplace: Cal Co Md

16. Informant: Lillie Wood
Address: 304 Severn Ave W. Annapolis

17. Buried (Burial, cremation, or removal, Which?) Date thereof June 9. 1945 (mooth) (day) (year)
Cemetery or crematory: Mt Zion Mem.
Location: Fairfield, Md.
18. Funeral director: H. C. Dawkins & Son
Address: Galesville Md

19. June 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 1945, at 11 10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1 1943, to June 6 1945
and that I last saw h... alive on June 6 1945

	DURATION
Immediate cause of death: Myocarditis & Myocardial Degeneration (Abt)	2 yrs
Due to: Arteriosclerosis	Abt 5 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 mooths of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underlioe the cause to which death shoold be charged statistically.

22. VIOLENCE: If death was due to external causes, fill to the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Beal, M. D. or other
Address: Annapolis Md Date signed 6-7-45

B.W

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly!

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

Reg. Diat. No. 1578 528

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months 2 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 6 months 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Severna Park County: Ditto.

City or town: Maryland.

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Viola Wright

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Roland Wright

6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): 1919

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
26	unknown			

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housework

11. Industry or business: —

FATHER — 12. Name: Bailey Brown

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Emma Peters

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/21/45 (month) (day) (year)

Cemetery or crematory: Brewer Field

Location: Annapolis, Md.

18. Funeral director: C. B. Hasson

Address: Annapolis, Md.

19. 6/17/45 (Date rec'd by registrar) 19.. E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 19 45 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 14 19 44 to June 16, 19 45

and that I last saw h.. alive on June 16, 19 45

Immediate cause of death: General Paresis — DURATION: in hospital 6 months 2 days

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op.: —

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: — Date of:

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: Injured at work?

23. SIGNATURE: Albert V. Hinkwood M. D. or other

Address: Crownsville Date signed: 6-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING